Exhibit 1

CORRECTIONAL MANAGED CARE
INTAKE HISTORY AND HEALTH SCREENING

1721640

I. IDENTIFICATION

NAME: McCollum Jerry OCCUPATION: Driver EDUCATION: Dropout School

DOB: [redacted] COUNTY: McLennan PREVIOUS TDCJ #(s): _____

II FAMILY HISTORY

1 Blood disease (sickle cell anemia, hemophilia)	YES	NO	18 INH Prophylaxis	YES	NO
2 Cancer	YES	NO	19 Intravenous Drug Abuse	YES	NO
3 Diabetes	YES	NO	20 Kidney Disease	YES	NO
4 Heart Disease	YES	NO	21 Liver Disease	YES	NO
5 High Blood Pressure	YES	NO	22 Mental Illness	YES	NO
6 Tuberculosis	YES	NO	23 Non Intravenous Drug Abuse/Alcoholism	YES	NO

III PERSONAL HISTORY

1 D 1 Asthma/Emphysema	YES	NO	24 Peptic Ulcers	YES	NO
2 Back Injury	YES	NO	25 Rheumatic Fever	YES	NO
3 Blood Disease (sickle cell anemia, hemophilia)	YES	NO	26 Rheumatism/Arthritis	YES	NO
4 Cancer	YES	NO	27 Seasonal Allergies	YES	NO
5 Cavities	YES	NO	28 Sexually Transmitted Diseases	YES	NO
6 Depression/Suicide Attempt	YES	NO	29 Smoker	YES	NO
7 Diabetes	YES	NO	30 Tetanus Immunization Date	YES	NO
8 Drug/ Food Allergies	YES	NO	31 Tuberculosis	YES	NO
9 Epilepsy/Seizures	YES	NO	32 Unprotected Sex w/Multiple Partners	YES	NO
10 Glasses/Hearing Aid	YES	NO	33 Other		
11 Gum disease	YES	NO	**IV OBSTETRIC/GYNECOLOGICAL HX**	X	N/A
12 Head Injury	YES	NO	1 Date of last menstrual period		
13 Heart Disease/Angina	YES	NO	2 Number of pregnancies/live births		
14 Hepatitis	YES	NO	3 History of Problem pregnancy		
15 High Blood Pressure	YES	NO	4 Date of last pap smear		
16 HIV + / AIDS	YES	NO	5 Date of last mammogram		
Prior HIV Test Date		NO	6 History of birth control methods (IUD, pills, etc.)		
17 Homosexual/Bisexual Activities		NO			

A. If YES to any of the above indicate family member or self, give date and treatment received
Father, Brother

B History of hospitalization? YES NO
Please list the DATE, HOSPITAL, CONDITION Hillcrest Hospital

C. Do you have any current medical, mental health or dental complaints? YES NO
if yes, what tooth pain, Depression

D. Have you experienced any of these symptoms cough, weakness, weight loss, fevers, night sweats, loss of appetite or lethargy?
YES NO If YES, when?

E. What illegal drugs have you used? NO
What was the mode(s) of use? (Please circle) Smoking Injection Inhaled Ingested
What amount and how often did you use drugs and alcohol?
When was the last time you used drugs or alcohol?
Have you ever had withdrawal or seizures when you stopped using drugs or alcohol? YES NO

F Are you presently taking or supposed to be taking any prescribed medications? YES NO
If YES, what See Med Sheet

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	Reason for taking medications								
G	Observations	Tremor	YES	NO	Sweating	YES	NO	Other	
	Condition of skin	Cuts	YES	NO	Bruises	YES	NO		
		Sores	YES	NO	Other				
	Body & Movement	Deformities	YES	NO	Impaired Motor Activity	YES	NO		
		Other							
H	BEHAVIOR AND MENTAL STATUS								
	Hygiene & Appearance	✓ Clean, neat		Dirty, sloppy		Other			
	Orientation (ask questions and document response)								
	What is today's date?	7/15/11							
	What time is it?	Morning							
	What place is this?	Hutchins							
	Speech	✓ Normal		Loud		Soft		Mumbling	Other
	Attitude	✓ Appropriate		Laughing		Crying		Cursing	Quiet	Other
I	THOUGHT CONTENT (Please circle YES or NO)								
	Are you having current thoughts about suicide or self-injury?					YES	NO		
	Do you see or hear things that others do not see or hear?					YES	NO		
	Do you have any special powers abilities?					YES	NO		
	Do you receive personal messages from the TV or radio?					YES	NO		
	Do you have any phobias or excessive fears?					YES	NO		
J.	DISPOSITION								
	Routine referral to		✓ Medical		✓ Mental Health		✓ Dental		✓ CID
	Immediate referral to		✓ Medical		Mental Health		Dental		CID
	Release to general population		✓ YES		NO	Other			

Offender Signature:	Larry McCellon	Date:	7-15-11
Reviewer Signature	L.D. Haywood	Date:	7/15/11

Clifford RN 7/18/11

HSM-13 (6/08)